ASSESSMENT AND TREATMENT OF CONCURRENT GAMBLING AND MENTAL HEALTH DISORDERS

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- Arizona Department of Gaming
- 14th Annual Problem Gambling Symposium
- Phoenix, AZ
- 03/02/2020

DISCLOSURE

- Though this presentation is based partly on research supported by the Department of Veterans Affairs, it does not represent the view of the Department of Veterans Affairs or the United States Government
- The presenter has no financial investments with any of the treatment modalities or research discussed in this presentation

OVERVIEW

- Explore the relationship between gambling disorder and mental health disorders
- Discuss screening and assessment measures for gambling disorder
- Provide an overview of evidence-based treatments for Gambling Disorder
- Discuss emerging treatments and challenges in the concurrent treatment of gambling disorder and mental health conditions
- Provide examples of concurrent treatment plans with PTSD as a model

GAMBLING DISORDER: DSM 5 SUBSTANCE AND ADDICTIVE DISORDERS

Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12 month period:

a. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.

b. Is restless or irritable when attempting to cut down or stop gambling.

c. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.

d. Is often preoccupied with gambling

e. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).

f. After losing money gambling, often returns another day to get even ("chasing" one's losses).

g. Lies to conceal the extent of involvement with gambling.

h. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.

i. Relies on others to provide money to relieve desperate financial situations caused by gambling.

B. The gambling behavior is not better explained by a manic episode. (Or note due to medical condition- dopamine agonists)

Specify if:

Episodic or Persistent: Months between episodes?

Specify if:

Mild: 4–5 criteria met., **Moderate**: 6–7 criteria met, **Severe**: 8–9 criteria met.

REALITY OF THE MENTAL HEALTH CLINIC

Gambling disorder treatment is often reimbursed at lower rates, if at all, compared to mental health treatment

DSM 5 reclassification should help

Mental health or substance abuse clinics are often first place that individuals with gambling disorder seek assistance (but few do). Lack of gambling expertise in SUD services or MH.

"It doesn't seem like we've had many patients with a gambling problem"

Did you ask?

HOW COMMON ARE OTHER PSYCHIATRIC CONDITIONS IN GAMBLING DISORDER

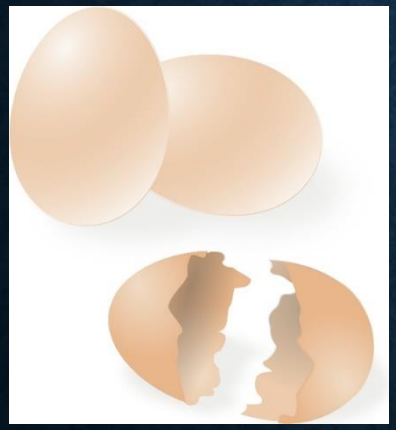
- As high as 96% of individuals with lifetime GD diagnosis have met criteria for another psychiatric disorder (Rash et al., 2016)
  - Depends on when/ how you're assessing
- No major changes in percentage of problem gamblers with current MH comorbidities from DSM-IV to DSM -5 (57 to 54%: Nicholson et al., 2019)
  - Compare to alcohol (25%) and cannabis (38%) use disorder
  - Rates did not include comorbid addictive disorders

MOST COMMON COMORBIDITIES SEEN IN PROBLEM GAMBLERS

Anxiety Disorders 17.6-41.3% (Grant & Chamberlain, 2015; Lorains et al., 2011)	Mood Disorders 23.1%-49.6% (Grant & Chamberlain, 2015 ; Lorains et al., 2011; Petry et al., 2005)	ADHD 25% (Grall-Bronnec et al., 2011)	Personality Disorders 60.8% (Petry et al., 2005)
Other substance use disorder 22-38.1% (Grant & Chamberlain, 2015 ; Petry et al., 2005)	Other behavioral addictions (Food, Sexual, Shopping, Gaming; Grant & Kim, 2003)	Alcohol use disorder 25%-75% (Petry et al., 2005; Welte et al., 2001)	Tobacco use disorder 60.4% (Petry et al., 2005)

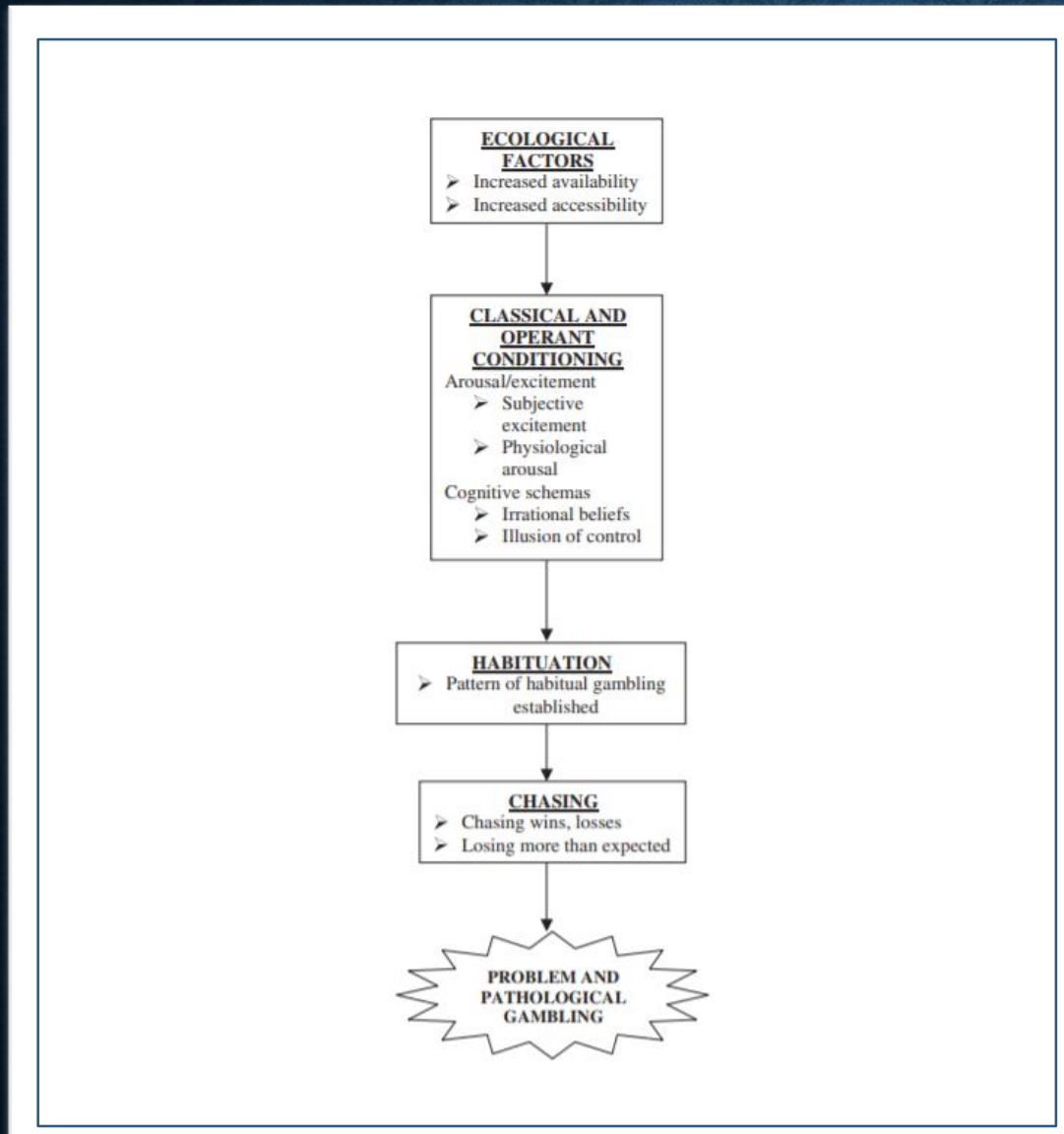
Most of previous studies analyzed correlations in treatment-seeking sample, but only 7-12% of individuals with a gambling problem seek treatment (Ford & Hakansson, 2019)

CHICKEN OR THE EGG??



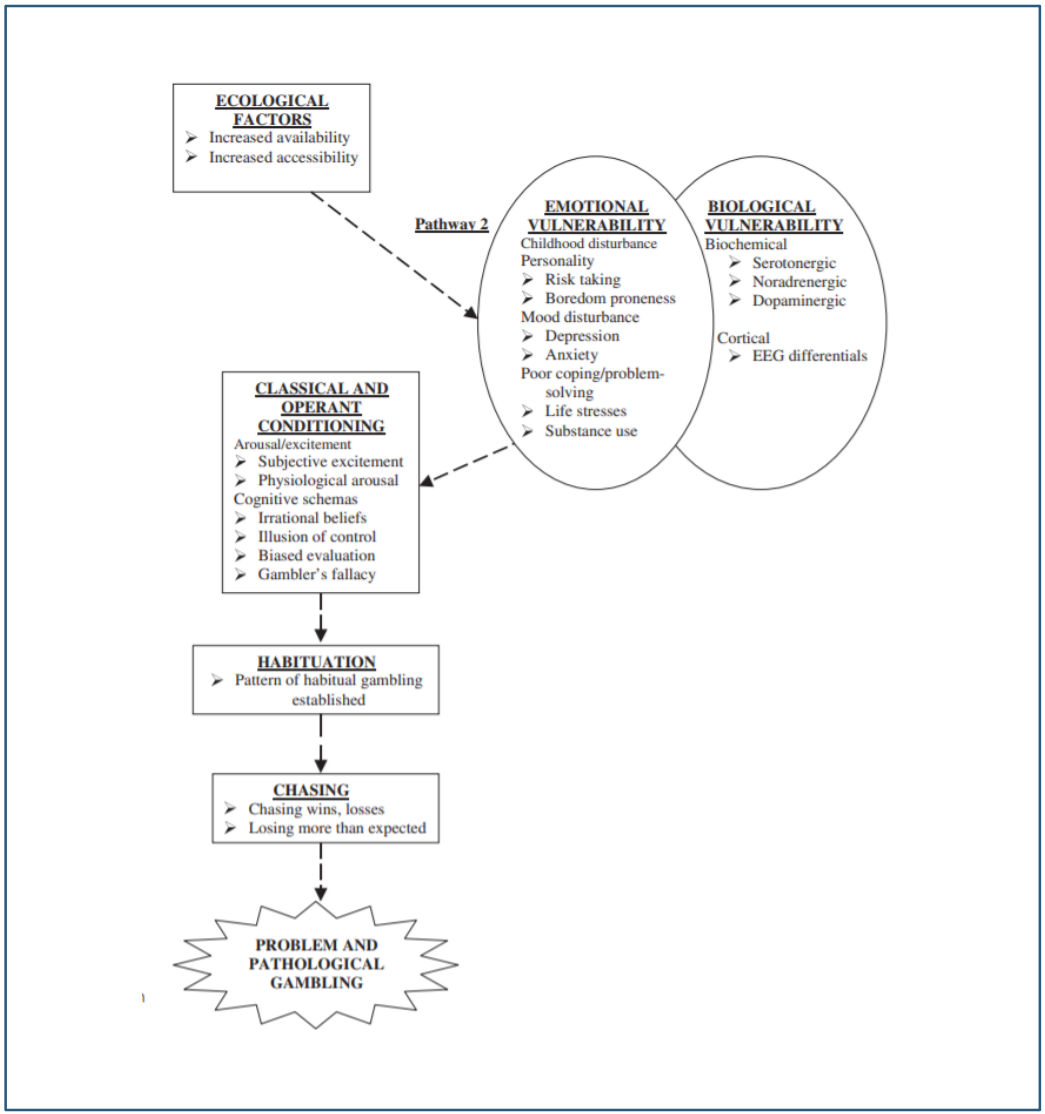
- Individuals with any level of gambling participation were at increased risk for mood, anxiety, and SUD compared to non-gamblers at three year followup (Parhami et al., 2014)
  - Gambling severity also predicted onset of psychiatric disorders
- Research on temporal relation between gambling and SUD mixed (Cho et al., 2002; Hall et al., 2000)
- Presence of concurrent MH condition often worsens prognosis in gambling treatment (Brandt & Fischer, 2019)
  - Likely share antecedent factors
- 70% of problem gamblers report that mood symptoms preceded gambling
  - Escape from negative mood states?
  - Pathways model (Blaszczynki & Nower, 2002)

THE PATHWAYS MODEL (BLASZCZYNKI & NOWER, 2002)



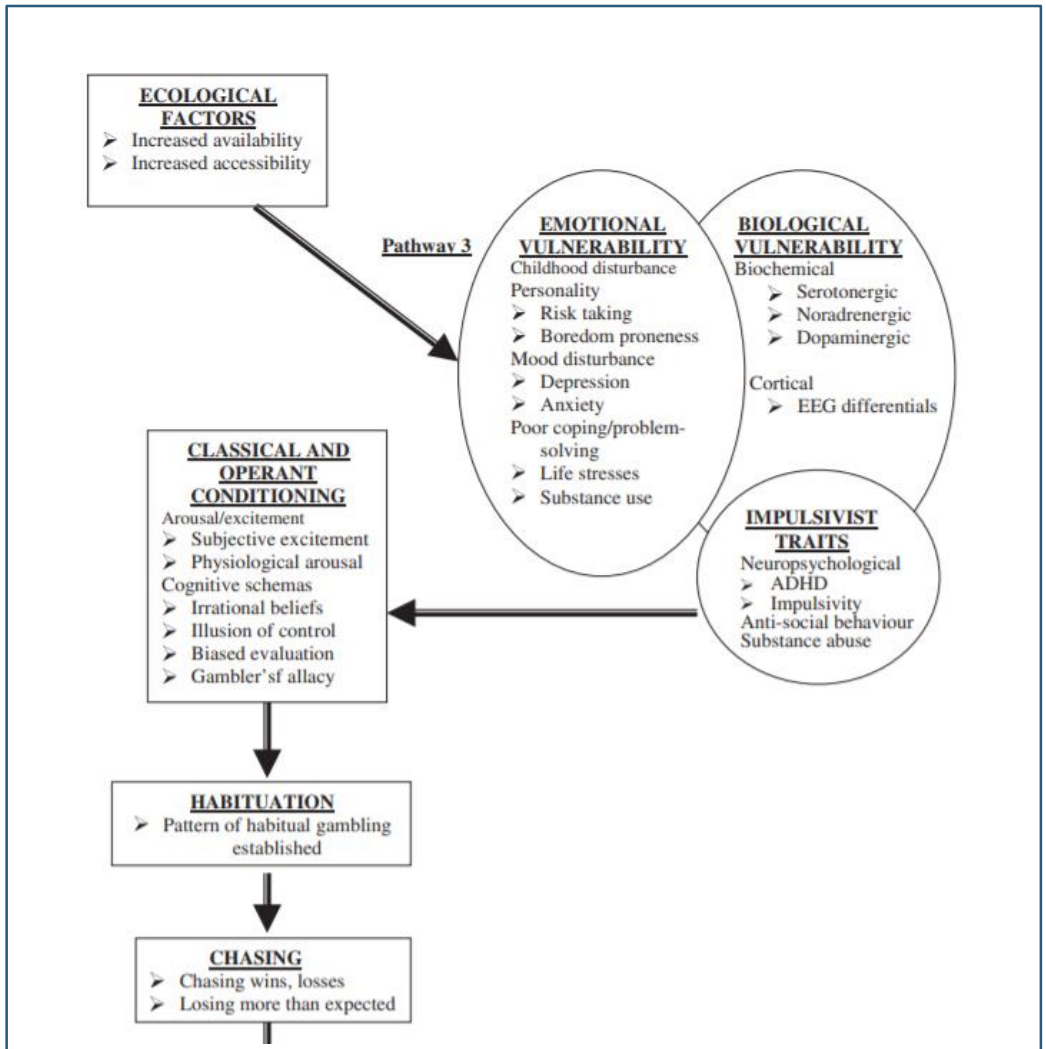
Pathway 1: Behaviorally conditioned gamblers

THE PATHWAYS MODEL (BLASZCZYNKI & NOWER, 2002)



Pathway 2: Emotionally Vulnerable Gamblers

THE PATHWAYS MODEL (BLASZCZYNKI & NOWER, 2002)



Pathway 3: Antisocial Impulsivist Gambler

EVIDENCE FOR/AGAINST PATHWAYS MODEL (MADEL, 2017)

- Subset of first-time problem gamblers without comorbid mental health conditions is likely
- Evidence also supports pathway differentiated by antisocial traits, impulsivity and comorbid mental health conditions prior to onset of problem gambling
  - Action gamblers
- Although Madel did not find evidence for pure Pathway 2, others have found that 3 factor model may fit well for screening
  - Gambling Pathways Questionnaire (Nower & Blaszcynski, 2017)— instrument not yet published

GAMBLING AS AN ESCAPE FROM EMOTIONAL PAIN

	Negative affect present in psychological disorders (e.g. physiological arousal, aversive emotional states) also elevated in problem gamblers (Green et al., 2017; Koob , 2009)	Effect may be bidirectional, leading to attempts to cope via gambling
	In treatment seeking Veterans with PTSD, endorsement of "escape item" in DSM 23 times more likely to be classified as problem gambler (Biddle et al., 2005)	Temporary relief of trauma-related symptoms such as hypervigilance or re-experiencing (Daghestani et al., 1996; Rundell et al., 1989)
	Certain games may promote dissociation or trance-like state (Wood et al., 2004)	Slots, scratchoffs

PERSONALITY TRAITS ASSOCIATED WITH GAMBLING DISORDER AND PTSD

- High levels of impulsivity common in PTSD, TBI, and gambling disorder (Kotler et al., 2001; Oquendo et al., 2005)
  - High impulsivity = poor treatment outcome (Leblond et al., 2003)
- Significant relation of impulsivity to problem gambling in SEM (Iliceto et al., 2015)
- Negative emotionality/neuroticism may underly gambling disorder and many mental health disorders

NEUROIMAGING IN PROBLEM GAMBLERS

- Inhibitory control deficits or incentive sensitization
  - Reduced activation to reward/ punishment (ventral striatum and PFC)
    - Positively correlated with gambling severity
    - Decreased attentional bias & responsivity to natural rewards
  - BUT…also increased ventral striatum dopamine release during gambling task in PG

  - Significant role of PFC in gambling behaviors
    - Results depend on type of task

SO WHERE DO WE START?

- Full biopsychosocial assessment that includes screening measures for gambling/behavioral addictions, mood disorders, trauma, substance abuse, suicidal ideation, and current stressors (e.g. relationship, finances) is needed to individualize treatment plan
  - Balance time needed for screening tools vs. information obtained
  - If we don't ask, we don't know
- Case conceptualization is not possible without collaboration with the patient
  - They are the expert on their experience
  - Case conceptualization is ongoing and fluid
- Impulsivity and emotion dysregulation are important to consider in treatment planning
- *Managers: Protect time for a real intake. Otherwise, your treatment plans may be way off base from what is needed.

THERAPEUTIC ASSESSMENT

- Identify motivations for treatment and conduct thorough functional analysis
- Assess previous exposure to treatment and modalities utilized
- Identify other comorbidities to prioritize treatment goals
- Collaboratively explore treatment options
- Comorbid PTSD predictive of treatment dropout in treatment-seeking gamblers (Maniaci et al., 2017)
    - Buy-in and rapport especially important with Veteran population

VERY BRIEF GAMBLING SCREENS

Brief Biosocial Gambling Screen

A "yes" answer to any of the questions means the person is at risk for developing a gambling problem.

1. During the past 12 months, have you become restless, irritable or anxious when trying to stop/cut down on gambling?	YES ☐	NO ☐
2. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?	YES ☐	NO ☐
3. During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare?	YES ☐	NO ☐

ICRG
INTERNATIONAL CENTER FOR RESPONSIBLE GAMING

www.icrg.org
www.divisiononaddiction.org

- Gebauer et al., 2010

Lie/Bet Questionnaire:

1. Have you ever had to lie to people important to you about how much you gambled?
2. Have you ever felt the need to bet more and more money?

Johnson et al., 1988

GAMBLERS ANONYMOUS 20 QUESTIONS

1. Did you ever lose time from work or school due to gambling?
2. Has gambling ever made your home life unhappy?
3. Did gambling affect your reputation?
4. Have you ever felt remorse after gambling?
5. Did you ever gamble to get money with which to pay debts or otherwise solve financial difficulties?
6. Did gambling cause a decrease in your ambition or efficiency?
7. After losing did you feel you must return as soon as possible and win back your losses?
8. After a win did you have a strong urge to return and win more?
9. Did you often gamble until all your money was gone?
10. Did you ever borrow to finance your gambling?
11. Have you ever sold anything to finance gambling?
12. Were you reluctant to use "gambling money" for normal expenditures?
13. Did gambling make you careless of the welfare of yourself or your family?
14. Did you ever gamble longer than you had planned?
15. Have you ever gambled to escape worry, trouble, boredom, loneliness, grief or loss?
16. Have you ever committed, or considered committing, an illegal act to finance gambling?
17. Did gambling cause you to have difficulty in sleeping?
18. Do arguments, disappointments or frustrations create within you an urge to gamble?
19. Did you ever have an urge to celebrate any good fortune by a few hours of gambling?
20. Have you ever considered self-destruction or suicide as a result of your gambling?

OTHER PROBLEM GAMBLING SCREENING INSTRUMENTS

- South Oaks Gambling Screen (Lesieur & Blume, 1987)

  Lifetime patterns and financial impact

- Massachusetts Gambling Screen (Shaffer et al., 1994)
- Problem Gambling Severity Index (PGSI)(Ferris & Wynne, 2001) –Score higher than 8, indicative of problem gambling.
- Diagnostic Interview for Gambling Schedule (DIGS-5)

ASSESSMENT OF COGNITIVE DISTORTIONS ASSOCIATED WITH GAMBLING

- Gambler's Fallacy
- Illusory Control
- Talismanic superstitions
- Behavioral superstitions
- Attribution errors
- Anthropomorphism
- Selective Memory
- Over-interpretation of cues
- Luck as variable
- Luck as trait
- Luck as contagious
- Probability biases
- Illusory Correlations

Information Biases Scale (Jefferson & Nicki, 2003)
Gambling Related Cognitions Scale (Raylu & Oei, 2004)

EXAMPLES OF GAMBLING COGNITIONS

- Gambling Cognitions Rating Scale (Raylo and Oei, 2004)
  - Gambling makes me happier
  - I can't function without Gambling
  - Gambling makes things better
  - Gambling helps reduce tension/ stress
  - I will never be able to stop
  - I collect objects that help increase my chances

ASSESSMENT OF FINANCIAL IMPACT

- Identify financial relation to gambling
  - Losses
    - Types of debt- credit, loans, withdrawals, unpaid bills, pawn, borrow from friends/family
  - Winnings! Included early and big wins
  - Crime
  - Budget- income vs spending, % gambled

EVIDENCE-BASED TREATMENTS FOR GAMBLING DISORDER:

WHAT WORKS AND FOR WHOM??

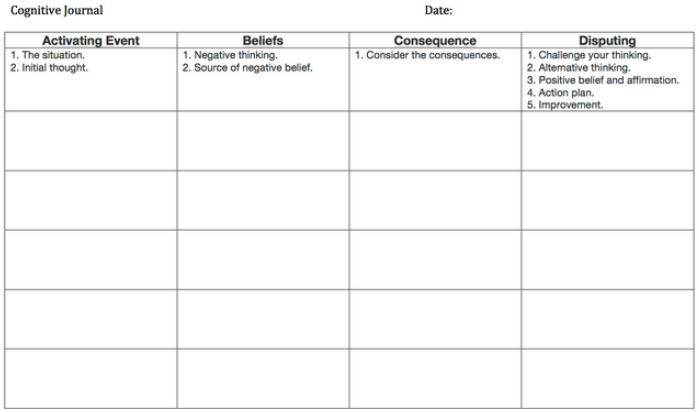
- Gamblers Anonymous
- Cognitive Therapy
- Cognitive Behavioral Therapy
- Motivational Interviewing
- Pharmacological Interventions

GAMBLERS ANONYMOUS

- Gambling disorder may respond similarly to treatment as substance use disorders
  - High Relapse Rates
- Gamblers Anonymous created as 12 Step support for individuals with gambling addiction
  - Disease model of addiction, encourages complete abstinence
  - Some groups provide peer-led financial coaching
  - Spirituality component
- 8% participation with reported abstinence at one year followup (Stewart & Brown, 1988)
- Individuals who attend GA while engaging in psychotherapy have better outcomes than psychotherapy alone (Hodgins et al., 2005; Petry, 2003)
- Gam-Anon: For family members, includes financial component and resources

COGNITIVE THERAPY OR CBT?

- Cognitive therapy attempts to correct cognitive distortions associated with gambling
  - May have only short-term benefits (Petry, Ginley, & Rash, 2017 review)
  - Perhaps most effect in behaviorally conditioned problem gamblers?
- CBT integrates cognitive restructuring with behavioral interventions
  - Identifies external and internal triggers for gambling
  - Provides coping skills and relapse prevention strategies
- CBT has been delivered via internet and workbook, as well as by therapist
  - CBT with therapist had larger decreases in gambling behavior, but effects may also be short-term (Cowlishaw, 2012; Menchon et al., 2018)
  - Relapse may be associated with ongoing mental health concerns
  - High treatment dropout



Cognitive Journal Date:

Activating Event	Beliefs	Consequence	Disputing
1. The situation. 2. Initial thought.	1. Negative thinking. 2. Source of negative belief.	1. Consider the consequences.	1. Challenge your thinking. 2. Alternative thinking. 3. Positive belief and affirmation. 4. Action plan. 5. Improvement.

COGNITIVE THERAPY

- Correct cognitive distortions
  - Gamblers fallacy
  - "Skills"
  - Selective Memory
  - Illusion of control
  - Near-misses
- Imagery & role-play
- Thought recording
- Patterns of automatic thoughts
  - ABC sheets
- Psychoeducation
- Listing advantages/disadvantages
- Examine the evidence

BEHAVIORAL THERAPY

- Desensitization
  - Imaginal exposure with relaxation
  - Identification of triggers (internal/external)
  - Decrease urges and anxiety
  - Graduate to gambling cues (money in vivo)
- Imaginal exposure reported better outcomes than aversion or in vivo (Mconaghy, Blaszczynki, Frankova, 1991)
- Behavioral activation components

MOTIVATIONAL INTERVIEWING

- Person Centered Therapy
- Explore natural ambivalence related to change
- Enhancing intrinsic motivation
  - Reflective listening
    - OARS
  - Highlight change talk, soften sustain talk
- Can be used targeting behaviors related to gambling disorder and other comorbid mental health concerns, including SUD
- Solidity motivation to engage in future treatment
  - May be particularly useful in gambling, as 2/3 of patients don't engage after seeking treatment

MOTIVATIONAL INTERVIEWING CONT'D

- Cost-benefit analysis
- The road exercise
- Highlight change talk throughout
- No planning until permission given by Veteran or they start the process
- MET developed for comorbid mental health conditions (McGovern's MET PTSD)

PHARMACOLOGICAL INTERVENTIONS

- •N-Acetylcysteine, a glutamate-modulating agent, in treating gambling and smoking (Grant et al., 2014).
- Antidepressant or mood stabilizers may decrease impulsive gambling in patients with comorbid depression/ GAD (Pallesen et al., 2007 review)
- •Naltrexone (opioid antagonist) has shown efficacy in controlled trials (Bartely & Bloch, 2013)-combat cravings
  - Especially with comorbid AUD
- Sleep aids- Trazodone, Prazosin (nightmares)
- Benzodiazepines often contraindicated: Reduce exposure efficacy and may prevent learning of emotion regulation strategies

FINANCIAL MANAGEMENT

Initiate financial plan (Pressure Relief, Problem Gambling Toolkit)

Payment plans

Detailed budgeting

Reduce stress and urge to chase losses

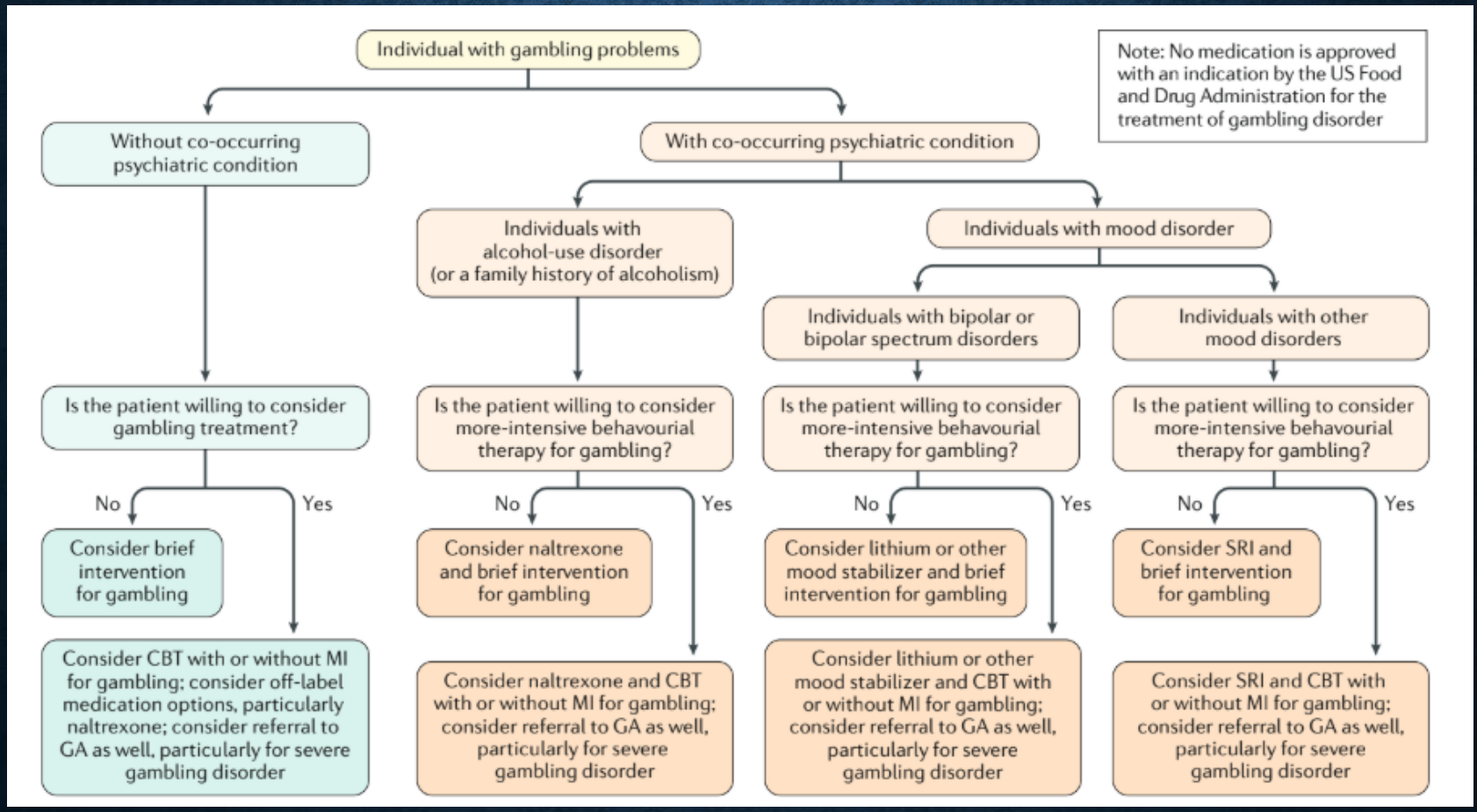
Contact all debtors

Self exclusion

Fixed amount of time, lifetime

Discuss removal on mailing lists

PROPOSED ALGORITHM FOR TREATMENT OF GAMBLING DISORDER



From Potenza et al., 2019

USING PTSD AS A MODEL FOR TREATMENT OF COMORBID GAMBLING AND MENTAL HEALTH DISORDERS

WHY PTSD?

PTSD is characterized by:

Exposure to a severe life-threatening event

Re-experiencing/ Intrusion

Avoidance

Negative cognitions and mood

Increased arousal & hypervigilance

Symptom clusters match well to pathways 2 and 3, especially when comorbid with TBI

ASSESSMENT OF INDEX TRAUMA

Criterion A should be clearly identified in any assessment of trauma

- Index trauma or closely related traumas
- Trauma-related symptoms associated with only index trauma(s)
- If multiple traumas, assess worst event (as identified by patient)

Life Events Checklist

- Useful for singular and complex trauma
- Explain rationale for use
- Monitor emotional reactivity (or lack thereof)

TYPES OF TRAUMA COMMON IN VETERAN POPULATION

- Combat and war-zone trauma
- Traumatic grief/loss
- Military sexual trauma
- Accidents
- Post-deployment stress

MILITARY TRAUMA IN WOMEN

- 2/3 of female OIF veterans report at least one combat experience (Milliken et al., 2007)
- 38% of OIF servicewomen are in firefights, and 7% report shooting at an enemy (Hoge et al., 2007)
- OIF servicewomen handle human remains more often than servicemen: 38% vs. 29% (Hoge et al., 2007)
- 21% of female veterans of Iraq and Afghanistan have been diagnosed with PTSD (VA, 2010)

MILITARY SEXUAL TRAUMA

- Military Sexual Trauma is sexual assault or sexual harassment that is threatening
- Among active duty personnel:
  - 3% of women and 1% of men reported attempted or completed sexual assault in the previous year
  - 54% of women and 23% of men reported sexual harassment in the previous year (DOD, 2002)
- Among veterans using VA health care:
  - 23% of women reported being sexually assaulted while in the military
  - 55% of women and 38% of men reported sexual harassment (VA, 2009)

ADDITIONAL RISK FACTORS

Two or more adverse childhood experiences (ACEs) are associated with increased risk of PTSD, beyond combat exposure (Cabrera et al., 2007)

- Increased risk for dissociative subtype

Childhood physical abuse and combat-related trauma *both* increase later anxiety, depression, and PTSD (Fritch et al., 2010)

Post-deployment stress and social support

PTSD: CRITERION B

Intrusion (1/5 needed)

- Recurrent, involuntary memories
- Nightmares
- Dissociative Reactions/ Flashbacks
- Intense or prolonged distress after reminders
- Marked physiological arousal after reminders

PTSD: CRITERION C

Avoidance (1/2 needed)

- Trauma-related thoughts or feelings
  - Gambling, SUD, attempts to numb
- Trauma-related external reminders
  - People, places, conversations, situations, activities, objects
  - Withdrawal, control of environment

PTSD: CRITERION D

Negative Alteration in cognitions or mood after traumatic event (2/7 needed)

- Inability to recall details of trauma
  - R/O drugs, injury
- Persistent negative beliefs about self and world
- Persistent distorted blame of self or others related to trauma
- Persistent negative emotions (e.g. fear, horror, anger, guilt, shame)
- Markedly diminished interest in significant activities
- Feeling alienated/ detached from others
- Constricted positive affect

PTSD: CRITERION E

Trauma-related alterations of arousal/reactivity (2/6 needed)

- Irritable or aggressive behavior
- Self destructive behavior
- Hypervigilance
- Exaggerated startle
- Concentration difficulties
- Sleep disturbances

ASSESSMENT OF TRAUMA-RELATED SYMPTOMS

PTSD Checklist 5- screening, not diagnostic in isolation

Clinician Administered PTSD Scale (CAPS-5)

- Thorough, diagnostic interview (1.5 hours)
- Excellent for treatment planning

Davidson Trauma Scale (DTS)

Dissociative Subtype of PTSD Scale (DSPS)

Impact of Event Scale - Revised (IES-R)

Mississippi Scale for Combat-Related PTSD (M-PTSD)

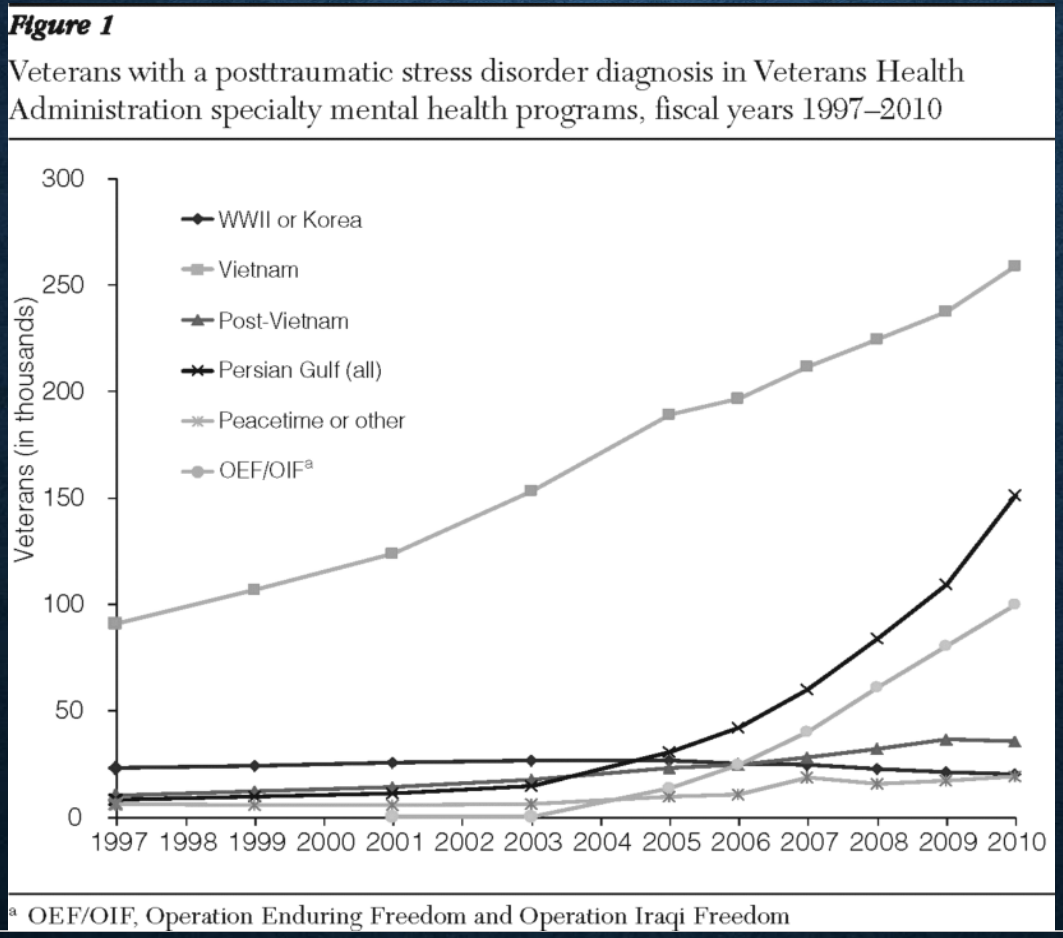
Modified PTSD Symptom Scale (MPSS-SR)

Posttraumatic Diagnostic Scale (PDS)

Trauma Symptom Checklist - 40 (TSC-40)

Trauma Symptom Inventory (TSI)

Increasing Numbers of Veterans with PTSD in VA System



Veterans with PTSD diagnosis in Veterans Health Administration specialty mental health programs, fiscal years 1997–2010 (Hermes et al., 2012)

CO-OCCURRENCE OF PTSD AND GAMBLING DISORDER

- PTSD and gambling disorder co-occur at a high rate
  - 12.9-29% of people with gambling disorders also have PTSD (Ledgerwood and Petry, 2006; Najavits et al., 2011)
  - 17-29% of Veterans seeking treatment for PTSD classified as problem gambler (Biddle et al., 2005)
- Gambling disorder may predict future onset of PTSD (Kessler et al., 2008)
- Traumatic life events correlated with and exacerbate severity of gambling behaviors (Peltzer et al., 2006; Scherrer et al., 2007)

PTSD AND GAMBLING FOLLOWING MILITARY SEXUAL TRAUMA

Rates of PTSD for sexual assault are higher than those for combat

- 65% of men and 46% of women who have been sexually assaulted report PTSD symptoms, compared to 39% of men following combat

Sexual assault has been linked to increases in compulsive behaviors (hypersexual behaviors, disordered eating, & gambling: Nardecchia and Hungrige, 2015)

- Impaired inhibition/behavioral avoidance

COMMON CO-MORBIDITIES WITH PTSD

- Substance abuse
- Gambling
- Depression
- Traumatic brain injuries (TBI)
- Chronic pain
- Insomnia

Figure II-14: Overlapping of Multiple Health Issues [121]

DOD, 2012

INTEGRATED PTSD AND GAMBLING TREATMENT

Stages of Treatment (adapted from Herman, 1992)

I. Safety and Stabilization

Harm Reduction, Emotion Regulation, Psychoeducation, Craving Management

II. Remembrance and mourning

Trauma-Focused Therapy, CBT, Relapse Prevention

III. Reconnection

Values-based, reconnection with social supports/ family

TREATMENT OF PTSD AND GAMBLING DISORDER

Psychotherapies for Integrated Phase I Treatment

- Seeking Safety (Najavits et al., 2013)
- Motivational Interviewing
- Therapies for management of negative emotional states
  - MBRP, DBT, STAIR
- Therapy for specific symptoms
  - Imagery Rehearsal Therapy
  - CBT (e.g. comorbid pain, insomnia, substance use)

SEEKING SAFETY***

- 25 Session Protocol focused on coping in the present
  - Compassionately explores relation between gambling & PTSD
  - Instillation of hope
  - NOT a trauma-focused therapy

<u>Themes</u>

1. Develop commitment to practicing safety (harm reduction)
2. Master coping skills (responses to symptoms)
3. Utilize safety planning (relapse prevention)
4. Report unsafe behaviors (asking for help)
5. Utilize Safety plan (response to urges)

SEEKING SAFETY CONT'D

- Harm reduction or abstinence: patient choice
- Anyone can participate (no exclusions)
- Group or individual
- Psychoeducation + Process Therapy
- Adapt to any addictions or subthreshold PTSD
- Empowers the patient to take ownership of recovery
- Weekly homework assignment with followup next session
- No discussion of trauma details
- Natural transition to Creating Change

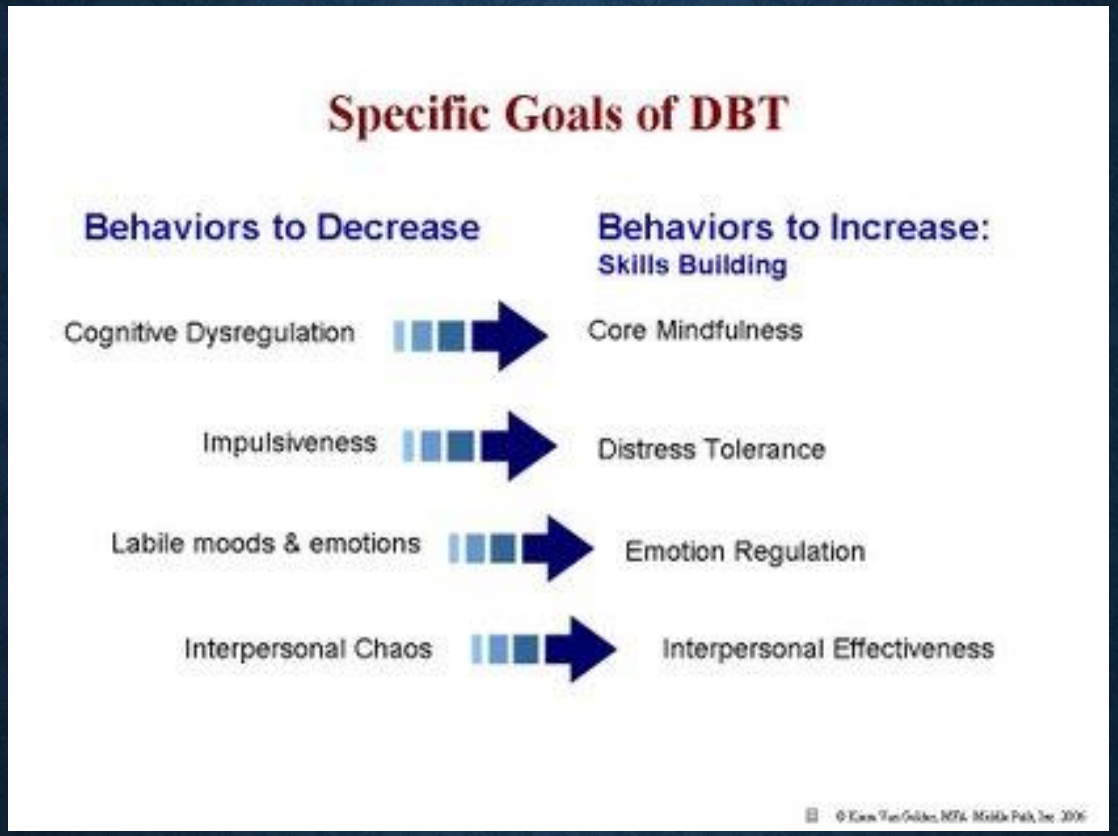
SEEKING SAFETY TOPICS

- **Behavioral , Interpersonal, Case Management, Cognitive**
  - Detaching from Emotional Pain: **Grounding**.
  - Taking Good Care of Yourself.
  - Red and Green Flags.
  - Commitment.
  - Coping with Triggers.
  - PTSD: Taking Back Your Power
  - Self-Nurturing
  - Asking for help
  - Healthy relationships
  - Community Resources

MINDFULNESS BASED RELAPSE PREVENTION

- Targets craving and negative affect
- Awareness and tolerance of int./ext. triggers
- Present-focused, intentional engaging of attention (as opposed to reactive attentional bias)
- Strengthens top-down inhibitory processing (Westbrook et al., 2014)

    But also reduces bottom-up reactive processing



DIALECTICAL BEHAVIOR THERAPY (LINEHAN, 1993)

SKILLS TRAINING IN AFFECTIVE AND INTERPERSONAL REGULATION (CLOITRE, 2002)

- 8 Sessions: Individual or group
- Developed for use with trauma survivors
  - Targets emotional and interpersonal dysregulation and impulsivity
- Goals
  - Increase emotional awareness
  - Distress tolerance and impulse reduction
  - Agency and flexibility in relationships

TRAUMA PROCESSING AND CBT FOR GAMBLING DISORDER

Emerging Psychotherapies for Integrated Phase II Treatment:

- Merging CBT for Gambling Disorder with other evidence-based treatment
- Trauma Processing
- Creating Change (Najavits, 2014)
- Concurrent Treatment of PTSD & addictive behavior using Prolonged Exposure (COPE: Back et al. 2014)

EVIDENCE-BASED PSYCHOTHERAPIES FOR PTSD

- Cognitive Processing Therapy (CPT)
- Prolonged Exposure (PE)
- Eye Movement Desensitization and Reprocessing (EMDR)

COGNITIVE PROCESSING THERAPY (RESICK & SCHNICKE, 1992)

- Group or Individual Format: Socratic Questioning not correction
- 12 sessions: Education, Impact Statement, Thoughts & Feelings, Remembering Traumatic Events, Challenging Questions, Patterns of Thinking, Challenging Beliefs,
- 5 Themes: Safety, Trust, Power/ Control, Esteem, Intimacy
- CPT includes a written trauma account/ impact statement, along with ongoing practice of cognitive skills
    - Identify assimilated or over-accommodated stuck points
    - Challenge with worksheets and Socratic dialogue
- CPT-C omits trauma account
    - Preliminary evidence suggests treatment is just as effective without the account

COGNITIVE PROCESSING THERAPY (RESICK & SCHNICKE, 1992)

SAFETY

- I cannot protect my family or myself.
- The world is completely dangerous.

TRUST

- Other people should not trust me.
- People can not be trusted to do what they are supposed to.

POWER/CONTROL

- I must be in control of my feelings at all times.
- People in authority always abuse their power.

ESTEEM

- I deserve to have bad things happen to me
- I'm not worth getting better.

INTIMACY

- I am unlovable because of the trauma.
- If I let other people get close to me, I'll get hurt again.

COGNITIVE PROCESSING THERAPY STUCK POINT ORIGINS

Just world hypothesis: Good things happen to good people, bad things happen to bad people

Assimilation: Trauma occurs, beliefs not changed.

Over-accomodation: Trauma occurs, drastic swing in beliefs

"INNOCENT PEOPLE WERE KILLED"
FROM WHITEHEAD, 2014

Assimilate

- I should have prevented it.
- It was my fault.
- I deserve to have bad things happen to me.
- It didn't really happen.

Accommodate

- Mistakes were made.
- Although lives were lost, many lives were saved.
- Sometimes bad things happen to good people.

Overaccomodate

- Government cannot be trusted.
- Nowhere is safe (I must stay on guard at all times).
- I am powerless.

PROLONGED EXPOSURE (FOA & ROTHBAUM, 1998)

- 8-12 90 minute sessions
- Psychoeducation on trauma & avoidance
- Breathing retraining (PTSD Coach APP)
- In vivo exposure
  - Repeated exposure to situations and objects that provoke distress but are not inherently dangerous
  - Engagement in pleasurable activities (due to emotional numbing and loss of interest or participation in previously enjoyed activities)
- Imaginal exposure
  - Repeated revisiting of trauma memory and processing of reaction to this experience (including feelings and thoughts about the trauma or its' meaning)
- Decrease symptoms of PTSD by actively learning that the trauma-related memories and cues are not dangerous and do not need to be avoided

PROLONGED EXPOSURE SESSIONS

- 1: Psychoeducation, Trauma Assessment, Breathing Retraining
- 2: Introduce habituation, SUDS, in vivo hierarchy construction
- 3: Conduct imaginal exposure
  - Remember the trauma as vividly as possible
  - Eyes closed, Present tense, Stay with emotions
  - SUDS every ten minutes, repeat for 60 minutes
  - Discussion: Remember things not previously recalled? Easier or more difficult than anticipated? Would anything else have helped? Feeling in present? Any other thoughts
- 4-?: Discuss in vivo, repeat imaginal, drill to hot spots
- Termination: Review importance of continued engagement/ decreased avoidance

MODIFIED COPE (BACK, 2012)

- Similar to traditional PE protocol
- CBT for addiction integrated into each session
  - Psychoeducation on PTSD and gambling disorder relation
  - Craving awareness & management
  - Mindfulness of high-risk thoughts
  - Refusal Skills
  - Seemingly irrelevant decision
  - Anger awareness & Management
  - Relapse prevention

EYE-MOVEMENT DESENSITIZATION & REPROCESSING (EMDR: SHAPIRO, 1991)

- Varied number of sessions
- Cognitive, affective, and somatic levels of processing trauma across sessions
- While the client is engaged in eye movements or some other form of bilateral stimulation, he or she is experiencing various aspects of the index trauma
    - Unclear how/if eye movements increase efficacy of trauma processing
- The goal is the client's rapid processing of information about the negative experience, bringing it to an "adaptive resolution."
- 8 Stages:
    1. Client History and Treatment Planning
    2. Client Preparation
    3. Assessment
    4. Desensitization
    5. Installation
    6. Body Scan
    7. Closure
    8. Reevaluation

EYE MOVEMENT DESENSITIZATION REPROCESSING

- Goal is to process and consolidate traumatic memories while maintaining stability
- 8 Phases:
  - 1- Assessment & Treatment Planning
  - 2- Coping skills training
  - 3-6: Target and positive images identified
    - Traumatic memory reprocessed while following therapists' finger
  - 7-8: Closure/Journal, Re-evaluation

CREATING CHANGE (NAJAVITS)

- Still under development- ~ 15-25 sessions
- Past and process-oriented treatment
- Can be integrated or offered subsequent to Seeking Safety
- Three phases:
  I. Preparation
  II. Telling Your Story
  III. Recovery and Growth

PHASE 3: COMMUNITY INTEGRATION

- Few Evidence-Based Psychotherapies focusing on Phase III trauma treatment
  - Cognitive-Behavioral Conjoint Therapy for PTSD (Monson and Fredman, 2012)
  - Warrior to Soulmate
  - Acceptance and Commitment Therapy
  - Aftercare, peer support, community reintegration
    - Gam-Anon, GA, family education
    - NAMI F2F

COGNITIVE BEHAVIORAL CONJOINT THERAPY-PTSD

- Phase 1: Rationale and Education about PTSD and Relationships
- – Session 1 Introduction to Treatment
- – Session 2 Safety Building
- Phase 2: Satisfaction Enhancement and Undermining Avoidance
- – Session 3 Listening and Approaching
- – Session 4 Sharing Thoughts and Feelings – Emphasis on Feelings
- – Session 5 Sharing Thoughts and Feelings – Emphasis on Thoughts
- – Session 6 Getting U.N.S.T.U.C.K.
- – Session 7 Problem Solving
- Phase 3: Making Meaning of the Trauma(s) and End of Therapy
- – Session 8 Acceptance
- – Session 9 Blame
- – Session 10 Trust Issues
- – Session 11 Power and Control Issues
- – Session 12 Emotional Closeness
- – Session 13 Physical Intimacy
- – Session 14 Post-traumatic Growth
- – Session 15 Review and Reinforcement of Treatment Gains

ACCEPTANCE & COMMITMENT THERAPY

- Targets behavioral component of avoidance and cognitive entanglement
- We are very bad at avoiding, and it comes at great cost
  - Something is wrong with us if we can't
  - Consequences of avoidance strategies
  - Emotionally Exhausting
  - Shovel metaphor
- Mindful observance, thoughts are just thoughts

ACCEPTANCE & COMMITMENT THERAPY

Identify values

Values card sort

Relationships, engagement, joy

Committed action

Addresses unworkability of previously identified efforts

Identifies workable ways to live a valued life

BARRIERS TO INTEGRATED TREATMENT

- Standalone specialty clinics make collaboration & referrals difficult
- Lack of integrated screening/ assessment
- Concern about increase in gambling with trauma processing
- Belief that patients must be abstinent before trauma-focused work
- Minimal empirically validated treatments for comorbid PTSD and gambling disorder
- Patient ambivalence or distrust of treatment

RECOMMENDATIONS & LESSONS LEARNED

- Integrated screening for gambling and mental health disorders is necessary
- Know & utilize current resources in your area
  - Create a local library for patients/ staff
- Need for more research on effective treatments for comorbid gambling disorder and mental health conditions
  - Not necessarily need for new treatments
  - Preliminary research shows emotion regulation training may be essential in early recovery and concurrent treatment
  - Veterans prefer treatments addressing trauma symptoms first
  - Motivational interviewing and therapeutic assessment helps initial engagement
- Continue to explore ways to integrate services
  - CBT for gambling disorder in conjunction with trauma-focused treatment

THANK YOU!

QUESTIONS?